

**Calendar Year 2008 Summary of Benefits– Retirees Under Age 65  
Hanford Employee Welfare Trust (HEWT)**

<b>BENEFITS</b>	<b>UnitedHealthcare Medical Plan Retirees Under Age 65</b>
<u>Annual Out-of-Pocket Maximum</u>	In Network: \$2,000 / person Out-of-Network: \$4,000 / person
<u>Deductible</u>	In Network: \$400 / person Out-of-Network: \$600/ person
<u>Coinsurance</u>	In Network: 80% / 20% coinsurance Out-of-Network: 60%/ 40% coinsurance
<u>Office Visit/Urgent Care</u>	In Network: 80% / 20% coinsurance Out-of-Network: 60% / 40% coinsurance
<u>Preventive Care</u>	In Network: 100% some services Out-of-Network: 60% / 40% coinsurance
<u>Laboratory and X-Ray Services</u>	In Network: 80% / 20% coinsurance Out-of-Network: 60% / 40% coinsurance
<u>Chiropractic Care</u>	In Network: 80% / 20% coinsurance Out-of-Network: 60% / 40% coinsurance 20 visits per year limit
<u>Prescription Drugs</u>	(Provided by Express Scripts, Inc.) <u>Retail</u> (up to a 30-day supply) Generic: \$ 7 copay Brand Name Preferred: \$25 copay Brand Name, Non-preferred: \$40 copay <u>Mail Order</u> (up to a 90-day supply) Generic: \$14 copay Brand Name Preferred: \$50 copay Brand, Non-preferred: \$80 copay

\*80% or 60% indicates amount covered by the insurance company according to the contract; 20% or 40% indicates amount covered by claimant.

*Note: Deductibles apply to all services unless otherwise stated. This is a brief summary only. For more detailed information, refer to the summary plan description of benefits or the contract.*

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<b>BENEFITS</b>	<b>UnitedHealthcare Medical Plan Retirees Under Age 65</b>
<u>Inpatient Hospital</u>	<p style="text-align: center;">\$250 co-pay plus applicable coinsurance</p> <p>In Network: 80% / 20% coinsurance Out-of-Network: 60% / 40% coinsurance</p>
<u>Outpatient Hospital</u>	<p>In Network: 80% / 20% coinsurance Out-of-Network: 60% / 40% coinsurance</p>
<u>Emergency Care</u>	<p><u>In and Out-of-Network:</u></p> <p style="text-align: center;">\$100 per visit co-pay, plus applicable coinsurance</p> <p>In Network: 80% / 20% coinsurance Out-of-Network: 60% / 40% coinsurance</p>
<u>Ambulance</u>	<p><u>In and Out-of-Network:</u></p> <p>Emergency: 80% / 20% coinsurance Non-emergency: 60% / 40% coinsurance</p>
<u>Durable Medical Equipment</u>	<p>In Network: 80% / 20% coinsurance Out-of-Network: 60% / 40% coinsurance (Lifetime maximum of \$50,000)</p>
<u>Rehabilitation Services</u>	<p>In Network 80% / 20% coinsurance Out-of-Network 60% / 40% coinsurance</p> <p>Limited to 30 visits total per year for physical, occupational and speech therapy; and 20 visits total per year for pulmonary and cardiac rehabilitation therapy.</p>
<u>Mental Health Services</u> <u>Outpatient</u>    <u>Inpatient</u>	<p>In Network: \$20 individual visit; \$5 per group visit Out-of-Network: 50% of covered charges</p> <hr/> <p>In Network: 0% coinsurance Out-of-Network: Mental Health: 60% / 40% coinsurance Substance Abuse: 50% of covered charges</p>
<u>Chemical Dependency</u>	See above.
<u>Vision Exam</u>	Not covered.
<u>Optical Hardware</u>	Not covered.

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